

## § 412.102

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(2) For FY 2011 and FY 2012, the adjustment is as follows:

(i) For low-volume hospitals with 200 or fewer Medicare discharges (as defined in paragraph (a) of this section), the adjustment is an additional 25 percent for each Medicare discharge.

(ii) For low-volume hospitals with Medicare discharges (as defined in paragraph (a) of this section) of more than 200 and fewer than 1,600, the adjustment for each Medicare discharge is an additional percent calculated using the formula  $[(4/14) - (\text{number of Medicare discharges}/5600)]$ . The “number of Medicare discharges” is determined as described in paragraph (b)(2)(ii) of this section.

(d) *Eligibility of new hospitals for the adjustment.* For FYs 2005 through 2010 and FY 2013 and subsequent fiscal years, a new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets discharge requirements during the applicable fiscal year and has provided its fiscal intermediary or Medicare administrative contractor with sufficient evidence that it meets the distance requirement, as specified under paragraph (b)(2) of this section.

[75 FR 50414, Aug. 16, 2010]

### **§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.**

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in subpart D of this part, may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

(a) *First year adjustment.* The hospital's rural average standardized amount and disproportionate share payments as described in § 412.106 are adjusted on the basis of an additional amount that equals two-thirds of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amount and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

(b) *Second year adjustment.* If a hospital continues to be reclassified as rural, its rural average standardized amount and disproportionate share payments are adjusted on the basis of an additional amount that equals one-third of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amounts and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

[58 FR 46338, Sept. 1, 1993, as amended at 65 FR 47047, Aug. 1, 2000; 69 FR 49244, Aug. 11, 2004]

### **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.**

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration, which is available via the ORHP Web site at: <http://www.ruralhealth.hrsa.gov> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9A-55, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(4) For any period after September 30, 2004 and before October 1, 2006, a CAH

in a county that, in FY 2004, was not part of a MSA as defined by the Office of Management and Budget, but as of FY 2005 was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in §485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

(5) For any period after September 30, 2009, and before October 1, 2011, a CAH in a county that, in FY 2009, was not part of an MSA as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on November 20, 2008, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in §485.610(b) of this chapter if it meets any of the requirements under paragraph (a)(1), (a)(2), or (a)(3) of this section.

(b) *Application requirements*—(1) *Written application*. A hospital seeking reclassification under this section must submit a complete application in writing to CMS in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) *Contents of application*. An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) *Mailing of application*. An application must be mailed to the CMS Regional Office by the requesting hospital and may not be submitted by facsimile or other electronic means.

(4) *Notification by CMS*. Within 5 business days after receiving the hospital's application, the CMS Regional Office will send the hospital a letter acknowledging receipt, with a copy to the CMS Central Office.

(5) *Filing date*. The filing date of the application is the date CMS receives the application.

(c) *CMS review*. The CMS Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) *Effective dates of reclassification*. (1) Except as specified in paragraph (d)(2) of this section, CMS will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital's complete application is received in CMS by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, CMS will consider the filing date to be January 1, 2000.

(e) *Withdrawal of application*. A hospital may withdraw an application at any time prior to the date of CMS's decision as set forth in paragraph (c) of this section.

(f) *Duration of classification*. An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Cancellation of classification*—(1) *Hospitals other than rural referral centers*. Except as provided in paragraph (g)(2) of this section—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period.

(ii) The hospital's cancellation of the classification is effective beginning with the next full cost reporting period.

(2) *Hospitals classified as rural referral centers*. For a hospital that was classified as a rural referral center under §412.96 based on rural reclassification under this section—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

(ii) The hospital's cancellation of the classification is not effective until it has been paid as rural for at least one 12-month cost reporting period, and not

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until the beginning of the Federal fiscal year following such 12-month cost reporting period.

(iii) The provisions of paragraphs (g)(2)(i) and (g)(2)(ii) of this section are effective for all written requests submitted by hospitals on or after October 1, 2007, to cancel rural reclassifications.

[65 FR 47048, Aug. 1, 2000, as amended at 69 FR 49244, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 70 FR 47486, Aug. 12, 2005; 72 FR 47411, Aug. 22, 2007; 74 FR 43997, Aug. 27, 2009]

### § 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into MS-DRG 652 (Renal Failure), MS-DRG 682 (Renal Failure with MCC), MS-DRG 683 (Renal Failure with CC), MS-DRG 684 (Renal Failure without CC/MCC) and MS-DRG 685 (Admit for Renal Dialysis), where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges.

(b) *Additional payment.* A hospital that meets the criteria of paragraph (a) of this section is paid an additional payment for each ESRD beneficiary discharge except those excluded under paragraph (a) of this section.

(1) The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital.

(2) The estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983 multiplied by the average cost of dialysis for the same period.

(3) The average cost of dialysis includes only those costs determined to be directly related to the dialysis service. (These costs include salary, employee health and welfare, drugs, supplies, and laboratory services.)

(4) The average cost of dialysis is reviewed and adjusted, if appropriate, at the time the composite rate reimburse-

ment for outpatient dialysis is reviewed.

(5) The payment to a hospital equals the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (a) of this section. This payment is made only on the Federal portion of the payment rate.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992; 69 FR 49244, Aug. 11, 2004; 73 FR 48755, Aug. 19, 2008]

### § 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

CMS makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* CMS determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents (except as limited under paragraph (f) of this section) to the number of beds (as determined under paragraph (b) of this section).

(i) Except for the special circumstances for Medicare GME affiliated groups, emergency Medicare GME affiliated groups, and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section for cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents.

(ii) The exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based